Trilogy
Homegrown Health Care

Authorization Request Form

Neuro/Psychological Testing

An intake evaluation must be completed before a request for testing will be considered. Testing for learning disability, attention deficit disorders and disability evaluations is not covered. Rating scales, checklists, inventories and questionnaires are not reimbursed as testing.

Patient's Name: _____ DOB: __/__/__ ID# _____

***Please attach a copy of the psychological intake and fax all to 608-245-3097 .**

Diagnosis Code(s):

_____

_____

_____

Has the patient had previous testing? ☐ Yes ☐ No

If yes, when?_____/_____/_____

What specific questions will be answered by the evaluation?

1. _____
2. _____
3. _____

Describe how the evaluation will help to implement the treatment plan:

_____

_____

Describe what other strategies/treatments have failed:

_____

_____

Specify the proposed measures and rationale for use:

Measure Name:_____CPT Code:_____Hours:_____

Rationale:_____

Measure Name:_____CPT Code:_____Hours:_____

Rationale:_____

Measure Name:_____CPT Code:_____Hours:_____

Rationale:_____

Measure Name:_____CPT Code:_____Hours:_____

Rationale: _____

Provider Name: _____

Facility Name:_____ NPI: _____

Address:_____Tax ID: _____

Contact Name:_____Phone:_____Fax: _____

The submission of supporting clinical documentation/plan of care is required with this form.